**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 334-9505

IN THE MATTER OF

[redacted]
**Appellant**

_____/

**Docket No.** 2010-46558 CMH
[redacted]

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The record was left open until [redacted] to receive the written testimony of the Appellant's spouse. It was timely received, marked and entered into the record as Exhibit #2. The Appellant appeared without representation. His spouse testified, in writing, post hearing. [redacted] Fair Hearings Officer, represented the Department. Her witness was [redacted], Supervisor of Adult Mental Health Services.

## ISSUE

Did the [redacted] Community Mental Health Authority (CMH) properly deny case management, psychiatric or health services to the Appellant?

## FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. At the time of hearing the Appellant is a [redacted], disabled, spend down Medicaid /Medicare SLMB beneficiary. (Appellant's Exhibit #1)

2. On assessment the Appellant is diagnosed with alcohol related disorder, NOS, and narcissistic personality disorder. The Appellant self-reports; "personality disorder" and "mental affliction" Bi polar disorder. He disputes these diagnoses. (Department's Exhibit A, pp. 1, 20 and *See* Testimony)

3. The Appellant is dyslexic.

4. The Appellant seeks assistance with obtaining medication to prevent seizures. (Appellant's Exhibit #1)

5. The Appellant is impoverished. (Appellant's Exhibit #2 – written testimony of spouse)

6. On [redacted], the Appellant was screened for service eligibility and found to be ineligible for requested case management as he has no Axis 1 disorder – accordingly, services were denied. (Department's Exhibit A, p. 1)

7. His behavioral Axis II traits were noted as problematic for the securing of services in any setting. (Department's Exhibit A, pp. 6-20)

8. The Appellant alternatively denies mental illness, claims "mental affliction" or "mental abuse" from mental health agencies across the country. His request for case management focuses on "problems with the system."

9. He reports dependence on the medication Klonopin and the desire to stop taking this medication. (Department's Exhibit A, p. 1, and See Testimony)

10. The Appellant reports a significant cardiac history. (Department's Exhibit A, p.1)

11. The Appellant was notified of his denial and his further right of appeal on [redacted]. (Department's Exhibit A, pp. 35, 36)

12. During his testimony on [redacted] the Appellant was agitated and reminded the Department of his right to services, his need for medications and his inability to afford co-pays. He testified," [M]y wife and I are living hand to mouth." (*See* Testimony of Haas)

13. The Appellant was never admitted to a psychiatric hospital. (Department's Exhibit A, p. 6)

14. The instant appeal was received by the State Office of Administrative Hearings and Rules (SOAHR) on [redacted]. (Appellant's Exhibit #1)

## CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> 42 CFR 430.0

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

Section 1915(c) of the Social Security Act provides:

> The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). [redacted] Community Mental Health SP (CMH) contracts with the Michigan Department of Community Health to provide those services.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.

*See* 42 CFR 440.230.

The MDCH/CMHSP Managed Specialty Supports and Services Contract, Sections 2.0 and 3.1 and Attachment 3.1.1, Section III(a) Access Standards-10/1/08, page 4, directs a CMH to the Department's Medicaid Provider Manual for determining coverage eligibility for Medicaid mental health beneficiaries.

The Department's Medicaid Provider Manual (MPM), Mental Health Chapter makes the distinction between the CMH responsibility and Fee For Service Medicaid.

The MPM sets out the eligibility requirements as follows:

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for service (FFS) Medicaid Program when experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDCH/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities. MPM, Mental Health [ ], §1.6, October 1, 2010, p. 4[1]

[1] This edition of the MPM is identical to the version in place at the time of notice and appeal.

[ ] **PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES**

> Medicaid covers psychiatric services for diagnostic or active treatment purposes. Psychiatric services are covered by the local PIHP/CMHSP for services included under the capitation payments to the PIHPs/CMHSPs, and a limited outpatient benefit is covered for beneficiaries enrolled in MHPs. Services to beneficiaries not included in the capitation payments to the PIHPs/CMHSPs and not enrolled in Medicaid.
>
> …. FFS limits outpatient visit coverage to a maximum of ten psychiatric visits in 12 months. Under FFS, only those psychiatric services personally rendered by a physician (MD or DO) are covered. Those services performed by other staff (e.g., psychologists, social workers, NPs, physician's assistants) are not covered.… MPM, Practitioner, §15.1, Psychiatric and Substance Abuse Services, October 1, 2010, p. 72

Furthermore, the Appellant remains eligible for emergency room services which encompasses an emergency resulting from "…an inability to provide food, clothing, or shelter for him or others, inability to attend to activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment." *Supra* at page 49.

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The CMH does not dispute that the Appellant has a diagnosis. However, they determined that the Appellant did not have a serious mental illness – properly - they referred him to the Ingham Health Department and provided him with a list of providers who accept Medicare. These actions [while fitting] may not have been enough action on the part of the CMH to satisfy its underlying obligation required under the MPM.

The proofs establish that the Appellant is a difficult client – he said so in his testimony and it is memorialized in the record. "When asked what his mental affliction was, client explained 'personality disorder. I like irritating people too bad.'" [*See* Department's Exhibit A, at page 1].

The documentary evidence reviewed and generated by the CMH spent a lot of time focusing on the Appellant's negative personality traits – even though clearly apparent at hearing. "I have an attitude problem," the Appellant said.

The testimony also established that the Appellant was delivering another message in his pleadings and testimony - perhaps missed by reviewers owing to his obstinence, i.e., he is impoverished and unable to meet co-pays for medication currently prescribed.

The Appellant and his spouse have recently returned to Michigan from New York and they are experiencing difficultly meeting medical expenses – they are both afflicted with some level of mental illness.

On review, the evidence supports the denial decision reached by the CMH on initial assessment. While obviously quarrelsome I believe the Appellant's testimony promises future compliance – if properly directed. The CMH is reminded that its contract with the Michigan Department of Community Health and the Medicaid Provider Manual, which while justifying the instant action, also expects them to assist beneficiaries in accessing Medicaid services.[2] Obviously, a beneficiary with the quarrelsome features presented by this Appellant requires greater effort - a fact this ALJ would expect the CMH to readily appreciate.[3]

The CMH is allocated general funds to meet its legislative mandate to serve the needs of those afflicted with serious mental illness – irrespective of Medicaid status. *See* MCL 330.1208 (1) and 330.1100c (6)

Because the CMH remains the entry point for mental health services in [redacted] – [redacted] Counties (assuming future medical necessity) the Appellant is free to seek those services whenever he wants – so long as he is not receiving duplicate services elsewhere. In this case, the evidence preponderates that his impairment is mild and thus subject to the treatment rubric available through FFS, Medicare or the [redacted] Health Department.

The Appellant has not preponderated his burden of proof that he is one afflicted with a serious mental illness.

## DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly determined that the Appellant was not eligible for services through the CMH.

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[2] *See* MPM, [Mental Health] §3, Covered Services, October 1, 2010 at page 15.

[3] As a long absent Michigan resident the Appellant's Medicare prescription drug benefits may - or may not - have caught up him, to wit; Monthly Part D premiums and cost-sharing amounts are not uniform nationwide, but vary across plans and regions, and have increased significantly on average since 2006. In 2010, the national average monthly Part D premium for all plans … is [redacted] …. Actual PDP premiums vary across plans and regions, ranging from a low of [redacted] in Oregon and Washington to a high of [redacted] in Delaware, Maryland and Washington, D.C. Individuals with modest incomes and assets are eligible for additional assistance with Part D premiums and cost sharing requirements., Beneficiaries with income below 150 percent of poverty ([redacted] for an individual; [redacted] for a couple in 2010) are eligible for the low-income subsidy (LIS) or "extra help", which helps pay for all or some of the Part D monthly premium, the annual Part D deductible, and prescription drug co-payments. The Centers for Medicare and Medicaid Services (CMS) estimates that of the 12.5 million beneficiaries potentially eligible for low-income subsidies as of February 2009, 2.3 million beneficiaries (18 percent) were not yet receiving them. *Medicare, a Primer, 2010,* The Henry J. Kaiser Foundation, pp. 7-8

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/8/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.